NOTICE OF ORDER OF EXEMPTION

The Department of Managed Health Care is issuing an Order exempting Medicare HMOs from certain Knox-Keene Act requirements pertaining to benefits and cost-sharing, coverage determinations, requirements related to the treatment and inclusion of providers, and requirements related to marketing materials (see attached Order). Medicare HMOs, which must be licensed by the Department, are health plans that contract with the federal Health Care Financing Administration (HCFA) to participate in the Medicare+Choice program.

Two federal laws passed in 1997 and 2000 include provisions that supersede state laws regulating Medicare HMOs in the following areas (see attached HCFA letter dated February 16, 2001):

- benefits requirements (including cost-sharing requirements);
- coverage determinations (including related appeals and grievance processes);
- requirements related to the treatment and inclusion of providers; and
- requirements related to marketing materials.

Until recently, California health plans that participate in the Medicare+Choice program have been required to apply to the Department for individual exemptions from these state requirements. This plan-by-plan approach has led to confusion among Medicare beneficiaries and HMOs.

By issuing the Order, the Department intends to eliminate this confusion. Exempting this class will ensure that all Medicare enrollees understand their rights, regardless of their HMO, and that all Medicare HMOs are held to clear and consistent standards. In addition, exempting the class through an Order – rather than on a plan-by-plan basis – will minimize administrative burden and free up dollars better spent on health care services.

California Medicare HMOs must continue to be licensed by the Department and comply with the state's many other quality of care, health care access and financial solvency standards – areas in which the Department will continue to exercise aggressive oversight. The Order does not provide an exemption from Knox-Keene requirements for California health plans in their non-Medicare business.

The Order is effective upon the date set forth therein and may be superseded by further Order of the Director.

Notwithstanding the exemptions relating to marketing materials found in the Attachment to the Order, the Department will continue to require that copies of all marketing materials related to Medicare+Choice products, including Evidences of Coverage and advertising, be filed with the Department for informational purposes.

DEPARTMENT OF HEALTH & HUMAN SERVICES Health Care Financing Administration
7500 Security Boulevard, C4-23-07
Baltimore, MD 21244

February 16, 2001

Dear Commissioner,

As you probably know, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) was enacted on December 21, 2000. There are several aspects of this new legislation that directly affect Federal and State regulation of Medicare+Choice organizations (M+COs). In particular, section 614 affects States' regulatory authority over benefits and marketing materials. I would like to take this opportunity to discuss the impact of these new provisions.

Section 614 of BIPA amends section 1856(b)(3)(B) of the Social Security Act such that it now reads:

(3) Relation to State law—

(B) Standards specifically superseded—State standards relating to the following are included under this paragraph:

(i) Benefits requirements ***(including cost-sharing requirements)*** [emphasis added]

(ii) Requirements relating to inclusion or treatment of providers

(iii) Coverage determinations (including related appeals and grievance processes)

(iv) ***Requirements relating to marketing materials and summaries and schedules of benefits regarding a Medicare+Choice plan.*** [emphasis added]

This language explicitly reverses HCFA's policy interpreting the pre-BIPA language to exclude restrictions on cost-sharing. Accordingly, M+COs are no longer required to follow State regulations relating to co-pays, deductibles and coinsurance that apply to benefits under a Medicare+Choice plan (whether original Medicare benefits or additional or supplemental benefits offered under the plan). In addition, section 1856(3)(B)(iv) specifically prohibits States from imposing requirements related to the content or review of marketing materials, including the Summary of Benefits and Evidence of Coverage documents. The term "marketing materials" is defined at 42 CFR 422.80(b) to include any informational materials targeted to Medicare beneficiaries that promote the M+CO or its plans or explain plan rules and benefits. Specific examples

include letters to members about changes in providers, premiums, benefits, or plan procedures and materials on rules involving confirmation of enrollment or disenrollment, or annual notification information.

The changes described above became effective with BIPA's enactment, and apply to marketing materials submitted after December 21, 2000, including those submitted to HCFA for review under BIPA. Because BIPA may have resulted in new benefits or changes in premiums that will be effective March 1, 2001, we have directed M+COs to notify beneficiaries of such changes immediately upon our approval of the changes. M+COs are directed not to delay sending such notices of changes to their beneficiaries, even if such changes have not been reviewed or approved by their States as those State functions can no longer be required under BIPA.

Regardless of the specific preemption of State marketing requirements, we are encouraging M+COs to file their marketing materials with State officials so that your offices may continue to have up-to-date information on M+COs. We assure you that HCFA will continue to review all required materials in accordance with existing regulations and guidelines. We intend to continue our practice of working with the National Association of Insurance Commissioners (NAIC) to strengthen the M+C Program.

Sincerely,

/s/
Gale P. Arden
Director
Private Health Insurance Group

/s/
Gary A. Bailey
Acting Director
Medicare Managed Care Group

cc: Regional Offices

STATE OF CALIFORNIA
BUSINESS, TRANSPORTATION AND HOUSING AGENCY
DEPARTMENT OF MANAGED HEALTH CARE

Order No. L-01-703

ORDER

UNDER SECTIONS 1343(b), 1344(a) AND 1367(i) OF THE HEALTH AND SAFETY CODE

Pursuant to Section 1343(b) of the Knox-Keene Health Care Service Plan Act of 1975, as amended ("Act"), the Director hereby exempts Knox-Keene licensed health care service plans ("Licensees") participating in Medicare+Choice contracts from the provisions of the Act specified herein; and pursuant to Section 1344(a) of the Act, the Director waives the requirements of California Code of Regulations Title 28, Section 1300.43 et seq. as specified herein.

Additionally, pursuant to Section 1367(i) of the Act, good cause having been demonstrated, Medicare+Choice contracts are exempted from the provision that all basic health care services included in Section 1345(b) of the Act be provided.

The provisions exempted include those attached hereto and incorporated herein by reference in Attachment A.

This Order shall remain in force and effect commencing on the date below until superseded by further Order of the Director which may amend, modify or terminate this Order.

Dated: March 7, 2001
Los Angeles, California

DANIEL ZINGALE
Director
Department of Managed Health Care

By: original signed by

BRIAN J. BARTOW
Chief
Licensing Division

EXEMPTED PROVISIONS

Sections of the Knox-Keene Health Care Service Plan Act of 1975, as amended (the "Act"):

1360*	1367.8	1368.5	1373.96
1361	1367.9	1370.2*	1374.5
1366.4(b)(c)	1367.11	1370.4	1374.7**
1367(h)-(j)	1367.21	1371.4	1374.11
1367.01	1367.22	1371.5	1374.12
1367.02 (c)	1367.24(a)-(d)	1371.8	1374.16
1367.05	1367.25	1373	1374.30
1367.09	1367.35	1373.3	1374.31
1367.2	1367.51	1373.4	1374.32
1367.215	1367.64	1373.7	1374.33
1367.3	1367.65	1373.8	1374.34
1367.54	1367.66	1373.9	1374.35
1367.6	1367.665	1373.11	1374.56
1367.61	1367.67	1373.12	1374.72
1367.62	1367.68	1373.13	1383.15
1367.63	1367.71	1373.14	1385***
1367.635	1368*	1373.19*	1395
1367.69	1368.01*	1373.20*	1395.5
1367.695	1368.1	1373.21*	1395.6
			1399.55

Sections of the California Code of Regulations Title 28 Subject to Waiver:

1300.61
1300.61.3
1300.63*
1300.63.1*
1300.63.2*
1300.65
1300.65.1
1300.67
1300.68*
1300.68.01*
1300.71.4

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*Exemption applies to the extent that provision relates to benefits requirements and coverage determinations (including related appeals and grievance processes).
** Exemption applies to second sentence of provision only.
***Exemption applies to section sentence of provision only.